DELTA DENTAL®

COMBINED EVIDENCE OF COVERAGE & DISCLOSURE FORM

For Employees of the

COUNTY OF SAN BERNARDINO

Group No. 1988

Effective Date: July 22, 2006

USING THIS BOOKLET

This booklet has been written with you in mind and is designed to help you make the most of your dental plan. It summarizes the terms and conditions of your coverage.

Individuals with special health care needs should carefully read those sections that apply to them (see **CHOICE OF DENTISTS AND PROVIDERS** section).

The "DEFINITIONS" section will explain to you any words that have special or technical meanings under your group Contract.

Keep in mind that YOU means the ENROLLEES whom Delta Dental covers. WE, US and OUR always refers to Delta Dental of California (Delta Dental). Plan Administrator refers to the County of San Bernardino's Chief of Employee Benefits and Services Division.

If you have any questions about your coverage that are not answered here, please check with Delta Dental or your Human Resources Department.

DELTA DENTAL OF CALIFORNIA
100 First Street
San Francisco, California 94105

For claims, eligibility and benefits inquiries, or additional information, call Delta Dental's Customer Service Department toll-free at 1-800-765-6003 or contact us on the Internet at web site: www.deltadentalins.com.

This booklet constitutes only a summary of the dental plan. The Contract also includes the Plan Document that should be consulted to determine the exact terms and conditions of coverage.

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DEFINITIONS

As used in this booklet, the following terms shall have the meanings specified below.

1. **Aesthetic Dentistry**: Dental procedure(s) whose primary benefit is to enhance an Enrollee's cosmetic appearance.

2. **Attending Dentist's Statement (ADS)**: A form completed by a Dentist to request payment for dental services or Pre-Determination of proposed dental treatment.

3. **Continuation of Coverage (COBRA)**: A method by which you and your Spouse, Domestic Partner and their Dependents who become ineligible for group coverage under the dental plan may continue their benefit coverage.

4. **Co-payment**: The amount you are obliged to pay your Dentist.

5. **County**: County of San Bernardino, districts governed by the Board of Supervisors of the County of San Bernardino, and any governmental entity affiliated with the County who has adopted the Plan by statute, ordinance or agreement, including the Superior Court of San Bernardino County.

6. **Covered Benefits**: Dental services and supplies that are covered under the terms of this Plan.

7. **Delta Dental PPO Dentist**: A Dentist with whom Delta Dental has a written agreement to provide services at the in-Network level for Enrollees in this Plan.

8. **Delta Dental PPO Dentist's Fee**: The fee that a Delta Dental PPO Dentist has contractually agreed with Delta Dental to accept for treating Enrollees under this Plan, or the Fee Actually Charged, whichever is less, for a Single Procedure.

9. **Delta Dental Dentist**: A Dentist who has signed an agreement with Delta Dental or a Participating Plan to provide services under the terms and conditions established by Delta Dental or the Plan.

10. **Deductible**: The amount you must pay before the Plan begins to pay benefits. Charges that are not "Covered Benefits" cannot be used to satisfy the Deductible.

11. **Delta Dental**: The designated Third Party Administrator or its successor duly appointed by the Plan Administrator.

12. **Dental Hygienist**: An individual who:

    a. Is licensed to practice dental hygiene by the government authority which has jurisdiction over the practice of dental hygiene in the area which services are rendered, and

    b. Works under the supervision of a Dentist.

13. **Dental Consultant**: A Dentist(s) employed by or acting as Delta Dental's agent who by virtue of training and experience is qualified to review the findings of the Dental Director for appropriateness of care and medical necessity.

14. **Dental Director**: A Dentist(s) employed by or acting as Delta Dental's agent who by virtue of training and experience is qualified to review dental treatment for appropriateness of care and medical necessity.

15. **Dentist**: An individual who is licensed as a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) in accordance with applicable state laws in which the dentist is licensed to practice and who is practicing within the scope of such license. The term "Dentist" shall include Network Providers and Out-of-Network Providers.

16. **Dependent**: An Employee's unmarried natural, adopted or stepchildren until they reach the age of 19 years except, if they attend a college or university on a full-time basis which has been accredited by the State Board of Education, then until they reach the limiting age of 24 years. Children past the age of 19 years who are mentally or physically incapable of self-care shall also be deemed a Dependent. The child must regularly reside with the Primary Enrollee and be a Dependent within the meaning of Internal Revenue Code Section 152. Proof of dependency in the form of a copy of a certified birth certificate or adoption record or such other form as may be acceptable by the Plan Administrator may be required.

17. **Domestic Partner:** means a person who, together with the Eligible Employee, has affirmed a domestic partnership with the County as defined by the County of San Bernardino.

18. **Effective Date**: The first date on which an Enrollee may receive benefits from this Plan.

19. **Elective Dentistry**: Dental procedures that are currently unnecessary to the dental health of the Enrollee or are not customarily employed nationwide for the treatment of a dental condition or are for Aesthetic Dentistry purposes only.

20. **Emergency**: A condition in which the Enrollee has severe pain or symptoms which, if not treated immediately, would lead to unnecessary suffering, disability or death.

21. **Emergency Services**: Services required for the alleviation of severe pain or symptoms which, if not treated immediately, would lead to unnecessary suffering, disability or death.

22. **Employee**: An individual who:

    a. Is employed by the County in a regular position scheduled for a minimum of forty hours and have received pay for at least one half plus one hour of scheduled hours in a Pay Period; or

    b. Is employed by the County in a regular position scheduled for a minimum of forty hours and have received pay for at least one half plus one hour of scheduled hours in a Pay Period, but is unable to work due to a federal or state-protected leave of absence; or

    c. Is employed in a regular position scheduled for a minimum of forty hours and have received pay for at least one half plus one hour of scheduled hours in a Pay Period by a district governed by the County Board of Supervisors or a government entity affiliated with the County including the Superior Court of San Bernardino County that has adopted the Plan for dental Benefits; or

    d. Has entered into an employment contract with the County or a district governed by the County Board of Supervisors or a government entity affiliated with the County that has adopted the Plan for dental Benefits.

23. **Employer**: The County of San Bernardino, districts governed by the Board of Supervisors of the County of San Bernardino, and any governmental entity affiliated with the County that has adopted the dental Benefit Plan by statute, ordinance or agreement, including the Superior Court of San Bernardino County.

24. **Enrollee**: A Primary Enrollee, Spouse or Domestic Partner or a Dependent who is eligible and enrolls for Covered Benefits or a person ceasing to meet such conditions who chooses a Continuation of Coverage.

25. **Enrollment Period**: The period of time allocated by the Plan for eligible persons to enroll. The period of time is stated in this Plan and is subject to change according to rules or regulations implemented by the Plan Administrator to administer the Plan.

26. **Exclusion**: A service that is not a Covered Benefit.

27. **Fee Actually Charged**: The fee for a particular dental service or procedure which a Dentist submits to Delta Dental on an Attending Dentist's Statement, less any portion of such fee which is discounted, waived, or rebated, or which the Dentist does not use good faith efforts to collect from the Enrollee.

28. **Fund or Plan Fund**: The Premiums received from Primary Enrollees that are used to pay the expense of administering and paying for Covered Benefits.

29. **Incurred Date**: The Incurred Date is as follows:

    1. For dental appliance or change to dental appliance: the date the first impression is made;

    2. For a crown, a bridge, or a cast restoration: the date the tooth or teeth are prepared;

    3. For a crown therapy: the date the pulp chamber is opened for therapy; and

    4. For all other dental procedures or other changes: the date the service or procedure is performed, or the supply or materials are furnished.

30. **Injury**: Means all injuries sustained by an Enrollee in one incident.

31. **Medically Necessary**: Care that is appropriate for the condition being treated, in accordance with the standards of sound medical or dental practice, and not for the convenience of the Enrollee or provider of services. To be considered medically necessary, the service must be one that, if not performed, would adversely affect the Enrollee's condition. The mere fact that a doctor or Dentist recommends or orders the treatment does not mean that it is Medically Necessary. Medical necessity also applies to the type of facility in which the Enrollee receives care. For example, hospitalization would not be Medically Necessary for care that could be provided in an outpatient setting.

32. **Network Provider**: A Delta Dental PPO Dentist.

33. **Notice of Payment (NOP)**: A statement provided by the Third Party Administrator to the Enrollee following the receipt by the TPA of a claim for services rendered by a Network or Out-of-Network Provider. The NOP outlines which services were covered under the Plan, the portion of the services that are payable by the Plan Fund, and the portion that is the Enrollee's obligation. The NOP will also list which services, if any, were denied for payment and the reason for denial.

34. **Open Enrollment Period**: A period of time designated by the County which occurs no less frequent than annually, during which eligible Primary Enrollees may submit Dental Plan enrollment changes, including changing from one plan to another or adding or deleting Dependents.

35. **Out-of-Network Provider**: A Dentist who is not a Delta Dental PPO Dentist. Enrollees using Out-of-Network Providers may have greater Co-payments than when using a Delta Dental PPO Dentist.

36. **Pay Period**: A continuous period of 14 days as established by the County for the purposes of processing payroll.

37. **Plan**: The County's Self-Funded Employee Dental Plan described in this booklet known as the County of San Bernardino Delta Dental PPO Dental Plan.

38. **Plan Year**: A continuous period of approximately 12 months as established annually by the Plan Administrator for the purpose of administering the County's Dental Plan.

39. **Plan Administrator**: The County Human Resources Department, Human Resources Division Chief for Employee Benefits and Services.

40. **Plan Amendment Date**: The date(s) that Plan changes are approved by the County Board of Supervisors.

41. **Plan Document**: The document which sets forth the provisions and administration of the County's Self-Funded Employee Dental Plan.

42. **Plan Sponsor**: The County of San Bernardino, districts governed by the Board of Supervisors of the County of San Bernardino, and any governmental entity affiliated with the County that has adopted the Plan by statute, ordinance or agreement, including the Superior Court of San Bernardino County.

43. **Pre-Determination of Covered Benefits**: A determination made by the Third Party Administrator, at the request of an Enrollee or Dentist subject to limitations, exclusions, Co-payments, maximum benefits, and other Plan terms, as to the scope of coverage under the Plan with respect to contemplated services. Such determination is not a promise or assurance by the Third Party Administrator that the Plan shall pay for contemplated services. The contemplated services are subject to retrospective claim review by the Plan after the actual dental service has been provided to the Enrollee.

44. **Premium**: A designated contribution amount established by the County and paid by a Primary Enrollee for the purchase of coverage under this Plan.

45. **Primary Enrollee**: An individual, who by their employment with the County, is eligible for Covered Benefits under the Plan. A Primary Enrollee shall also include the individual who is the head of a family unit (one-party, two-party or family) who is eligible for Covered Benefits due to election of Continuation of Coverage.

46. **Single Procedure**: A dental procedure to which a separate Procedure Number has been assigned by the American Dental Association in the current version of Current Dental Terminology.

47. **Qualified Beneficiary**: An Employee, Spouse, Domestic Partner or Dependent Enrollee who may be given the opportunity to elect Continuation of Coverage within the election period.

48. **Qualifying Event**: 1) A specific life event or status change consistent with Section 125 of the Internal Revenue Service Code and the County's Benefit Plan Document as one that permits the addition or deletion of an Enrollee from this Plan at a time other than Open Enrollment; 2) A specified triggering event that causes, or will cause, a loss of coverage under this Plan, but permits the Enrollee to continue their benefits through Continuation of Coverage.

49. **Quality Assurance**: Those retrospective and prospective processes used by the Third Party Administrator which are designed to assure that Enrollees have access to and receive dental care within community norms and standards. Such processes are applied to Network Providers who have a contractual relationship with Delta Dental. Such processes include, but are not limited to, credentialing, pre-contractual office audits, grievance monitoring and resolution, appointment availability reporting, and random chart audit.

50. **Specialist**: A Dentist who is responsible for the specific specialized dental care of an Enrollee in one specific field of Dentistry such as endodontics, periodontics, pedodontics, oral surgery, or orthodontics.

51. **Spouse**: The legal spouse of an Employee. Proof of dependency in the form of a copy of the certified marriage license or such other form as may be accepted by the Plan Administrator as may be required.

52. **Third Party Administrator(s) (TPA)**: Delta Dental or such other parties contracted and approved by the County to act as its agent with the legally vested responsibility of administering this Plan, including the payment of claims and other administrative aspects of the Plan.

53. **Work Related Illness or Injury**: An illness or injury for which the individual is entitled to benefits under the applicable Worker's Compensation Law, Occupational Disease Law, or similar legislation.

ENROLLMENT

You, your Spouse or Domestic Partner and your Dependents must complete and give the County's Dental Plan Enrollment/Change Form to the County and pay the appropriate Premiums to become Enrollees.

The Dental Plan Enrollment/Change Form must include your name, social security number, address, telephone number and other information necessary to enroll.

When you enroll, you promise and agree to pay the Premiums and authorize the County to automatically deduct the amount from your pay.

You agree to the terms and conditions of the dental Plan upon enrollment. Coverage is effective on the first day of the Pay Period following the Pay Period in which Premiums are first collected.

Collection of Premiums and coverage periods are governed by the County's established procedures and are subject to change.

Coverage for Spouses, Domestic Partners and their Dependents generally becomes effective at the same time your coverage starts or on the Effective Date pre-designated by the County for those enrolled during an Open Enrollment Period.

Mid-year changes that are made as a result of a Qualifying Event is effective on the first day of the Pay Period following the Qualifying Event (See Continuation of Coverage for enrollment, coverage dates and Premium collection for continued coverage beyond normal periods.)

A. **Right to Receive and Release Information**. Upon enrollment in the Plan, you agree and authorize the Plan Administrator or Delta Dental, without further consent of or notice to you, to release or obtain from any Dentist, other dental health care provider, insurance company, health maintenance organization or other person or entity any information the Plan deems necessary to determine eligibility and to process benefit claims.

By enrolling in the Plan, you agree to cooperate with the Plan and Delta Dental in administering Plan Benefits. Whenever payments which should have been made by this Plan have been made by any other plan, you agree that this Plan shall have the right to reimburse the other plan the amount this Plan determines shall satisfy the coordination of benefits provision. Whenever this Plan pays out more than necessary, you agree that the Plan shall have the right to recover the excess payment from any person to whom such payments were made or any insurance company or other organization.

B. **New Employee**. Newly hired employees have 31 days from the date of hire to enroll eligible Dependents including a Domestic Partner.

C. **Current Primary Enrollees**. At each Open Enrollment Period, current Primary Enrollees have 31 days to enroll themselves and any eligible Dependents for participation in the Plan by completing and giving the appropriate enrollment forms to the Plan Administrator through their payroll clerk. If you are continuing coverage under COBRA, you will also have the opportunity to discontinue enrollment of any Dependents at this time.

D. **Mid-Year Enrollment**. Current Enrollees must wait until the Open Enrollment Period to add a Spouse, Domestic Partner or Dependent for participation in this Plan unless the Employee experiences an IRS qualified change in status/life event as follows:

1. Marriage;

2. Divorce (final decree) or legal separation;

3. Death of a Spouse, Domestic Partner or Dependent;

4. The birth of a child by Primary Enrollee or Spouse or Domestic Partner or the placement of a child by adoption or legal guardianship in the home of a Primary Enrollee;

5. Primary Enrollee's Spouse or Domestic Partner begins or ends full time employment;

6. An eligible Dependent child begins or ends full time employment;

7. A Dependent child's loss of eligibility due to age, student status, or marital status;

8. An increase or decrease in work hours which affects eligibility for County benefits;

9. Employee or Spouse, Domestic Partner begins or returns from an unpaid leave of absence; or

10. Any events established within the County Benefit Plan as a Qualifying Event.

E. **Procedure for Requesting Mid-Year Enrollment**. To request an addition or deletion of an Enrollee for coverage in the Plan beyond the Open Enrollment Period ("mid-year change"), the Enrollee must complete and deliver the following to the Plan Administrator within 31 days of the Qualifying Event:

1. **A Dental Plan Enrollment/Change Form.** Forms shall be made available to you upon request. Failure to submit the Dental Plan Enrollment/Change Form to the Plan Administrator within 31 days of the Qualifying Event shall result in the inability to add a newly eligible Spouse, Domestic Partner or Dependents until the next Open Enrollment Period and the forfeiture of any prior paid Premiums in the case of dis-enrollment from the Plan.

2. **A Benefit Plan Premium Conversion Election/Change Form.** The form may change at any time. This form is not required if the change does not result in a Premium change. Requests for Premium Conversion changes must be consistent due to the life event for which Employee is requesting the change and must meet the guidelines of County administrative policies, County contracts/agreements, Plan Documents, Internal Revenue Code Section 125, and such rules as County may implement.

3. **Documentation verifying the need for mid-year change.** Examples of acceptable documentation include, but are not limited to:

   a. Copies of certified birth, death or marriage certificates;
   b. Copies of certified copies of court papers for divorces, separations or adoptions; or
   c. Original letter from employer verifying loss or gain of Spouse's, Domestic Partner's or Dependent's employment.

F. **Effective Date of Mid-Year Changes**. A Spouse's, Domestic Partner's or Dependent's coverage is effective the first day of the Pay Period following the Qualifying Event provided an Enrollment/Change Form is submitted within 31 days of the Qualifying Event.

1. Exceptions:

   a. Newborns are covered on the date of their birth for the first 31 days during which the Primary Enrollee must enroll the newborn for participation in the Plan;
   b. Children placed for adoption are covered for the first 31 days from and including the date they are placed in the home during which the Primary Enrollee must enroll the adoptee for participation in the Plan.

2. You shall be billed retroactively for any Premiums owed as a result of the addition of the eligible Spouse, Domestic Partner or Dependents as of their date of eligibility. For example, if you marry on April 7 and notify Plan Administrator on April 20 to add a Spouse for coverage, you shall be billed retroactively to pay for the coverage for the eligibility period that began immediately after April 7.

3. Plan Administrator must receive the Dental Enrollment/Change Form(s) within 31 days of a qualified change in status/life event. If you do not submit the form and verification within 31 days, you shall be denied the opportunity to submit coverage changes until the next annual Open Enrollment Period.

ELIGIBILITY RULES:

Employees, their Spouses or Domestic Partners and their Dependents are eligible to enroll in the Plan as follows:

A. **Eligibility for Employees**. You must be an Employee in a regular position scheduled for a minimum of forty hours and have received pay for at least one half plus one hour of scheduled hours in a Pay Period.

You must complete and give an enrollment application and pay the required Premiums to the Plan Administrator. Your coverage starts on the first day of the Pay Period following the Pay Period in which Premiums are first collected.

B. **Eligibility for Spouses, Domestic Partners and Dependents**. Your Dependents are eligible to enroll for coverage if you are eligible and enrolled for coverage. Dependents are:

1. Your legal Spouse, Domestic Partner and their unmarried children from birth to 19 years of age.

2. Child(ren) who attend an accredited college, university or trade school on a full-time basis (as defined by that institution) are eligible until their 24th birthday.

3. Your child continues to be eligible for Dependent coverage if, within 31 days after the child loses Dependent status, you give proof to the Employee Benefits and Services Division that the child is incapable of earning a living due to mental or physical handicap. Your child must have been a covered Dependent immediately before the request for continued Dependent status. Children will continue to be considered Dependents under this rule as long as they remain unmarried and mentally or physically incapable of earning a living. You must submit annual proof of the continued incapacity.

4. The term "child(ren)" includes your Spouse's or your Domestic Partner's natural child(ren), legally adopted child(ren), stepchild(ren), and child(ren) for whom your are the legal guardian and child(ren) you support as a result of a valid court order. In all cases, the child must be unmarried, under the age of 19 (or 24 if a full-time student), and qualified as your Dependent for income tax purposes.

5. The County may require proof of eligibility, such as a copy of a certified marriage certificate, a copy of your registration of your Domestic Partnership, a birth certificate, court adoption order, Social Security Foster Care Agreement, proof of legal guardianship, and/or income tax return showing dependency.

Family and Medical Leave Act of 1993

You can continue your coverage if you take a leave of absence governed by the Family and Medical Leave Act of 1993. If you do not continue your coverage during the governed leave, it will be reinstated at the same Benefit level you received before your leave.

Uniformed Services Employment and Re-employment Rights Act of 1994

You can continue coverage for up to 24 months, if you take a leave governed by the Uniformed Services Employment and Re-employment Rights Act of 1994. If you make this election, you must submit any Dues necessary, which may include administrative costs, to your employer. If you do not continue your coverage during a military leave, it will be reinstated at the same Benefit level you received before your leave.

Coverage is reinstated on the day employment is resumed for Enrollees that are members of the National Guard or a military reserve unit absent from work due to active military duty. Any waiting period applied as a result of an Enrollee's absence from active employment due to service in the National Guard or military reserve unit shall be waived.

Dependent coverage is also extended to any child who is recognized under a Qualified Medical Child Support Order (QMCSO).

Dependents in military service are not eligible.

WHEN YOU ARE NO LONGER COVERED

1. Your dental coverage will end on the last day of the Pay Period in which you have less than 41 hours of paid time and/or the last day of the Pay Period in which Dues have been collected. Your coverage may be continued if you qualify for and pay for Optional Continuation of Coverage. Your Dependents' coverage ends when yours does, or as soon as they are no longer eligible Dependents, unless they choose to pay for Optional Continuation of Coverage.

2. When the Contract between Delta Dental and your employer is discontinued or canceled, your and your Dependent's coverage ends immediately.

CANCELING THIS PLAN

The County may cancel the dental plan at any time. Delta Dental may cancel their administrative services agreement with the County only on an anniversary date (period after the program first takes effect or at the end of each renewal period thereafter), or any time the County does not make payment as required by the Contract.

If your dental plan is terminated for any cause, Delta Dental is not required to predetermine services beyond the termination date or to pay for services provided after the termination date, except for Single Procedures begun while your Plan was in effect which are otherwise Benefits under the Contract.

If this dental Plan is canceled, you and your Dependents have no right to renewal or reinstatement of your Benefits.

YOUR BENEFITS

Your dental Plan covers several categories of Benefits, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice.

If your dentist discounts, waives or rebates any portion of your co-payment, Delta Dental pays the applicable percentage of the fee or allowance that was reduced, discounted, waived or rebated.

I. DIAGNOSTIC AND PREVENTIVE BENEFITS - (100%)

The Plan pays 100% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by your dentist. You are responsible for paying the difference between the amount paid and the amount charged by an out-of-network dentist.

Diagnostic - oral examinations (including initial examinations, periodic examinations and emergency examinations);
x-rays;
diagnostic casts;
examination of biopsied tissue; palliative (emergency) treatment of dental pain; and,
specialist consultations

Preventive - prophylaxis (cleaning);
fluoride treatment; and,
space maintainers

II. BASIC BENEFITS - (100% if provided by a Delta Dental PPO Dentist) (90% if provided by other dentists)

The Plan pays 100% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by your dentist or 90% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by a non-Delta Dental PPO Dentist. You are responsible for paying the difference between the amount paid by the Plan and the amount charged by an out-of-network dentist.

Oral surgery - extractions and certain other surgical procedures, including pre- and post-operative care

Restorative - amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)

Endodontic - treatment of the tooth pulp

Sealants - topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay

Adjunctive General Services - general anesthesia; office visit for observation; office visit after regularly scheduled hours;
therapeutic drug injection;
treatment of post-surgical complications (unusual circumstances); and
limited occlusal adjustment

III. PERIODONTIC BENEFITS - (90%)

The Plan pays 90% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by your dentist. You are responsible for your co-payment of 10% plus the difference between the amount paid by the Plan and the amount charged by an out-of-network dentist.

Periodontic - treatment of gums and bones that support the teeth

IV. CROWNS, JACKETS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS – (75% if provided by a Delta Dental PPO Dentist) (70% if provided by other dentists)

The Plan pays 75% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by your dentist or 70% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by an out-of-network dentist. You are responsible for your co-payment plus the difference between the amount paid by the Plan and the amount charged by an out-of-network dentist.

Crowns, Jackets, Inlays, Onlays and Cast Restorations are Benefits only if they are provided to treat cavities that cannot be restored with amalgam, silicate or direct composite (resin) restorations.

V. PROSTHODONTIC BENEFITS – (75% if provided by a Delta Dental PPO Dentist) (70% if provided by other dentists)

The Plan pays 75% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by your dentist or 70% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by an out-of-network dentist. You are responsible for your co-payment plus the difference between the amount paid by the Plan and the amount charged by an out-of-network dentist.

Construction or repair of fixed bridges, partial dentures and complete dentures are Benefits if provided to replace missing, natural teeth

VI. ORTHODONTIC BENFEITS – (50%)

The Plan pays 50% of the lesser of the Delta Dental PPO Dentist's Fee or the Fee Actually Charged by your dentist. You are responsible for your co-payment of 50% plus the difference between the amount paid by the Plan and the amount charged by an out-of-network dentist.

Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly.

MAXIMUM AMOUNTS

The maximum amount payable by the Plan for Diagnostic, Preventive, Basic, Periodontic, Crowns, Jackets, Inlays, Onlays and Cast Restorations and Prosthodontic Benefits to each Enrollee in a calendar year is **$1,700.00.**

The maximum amount payable by the Plan for Orthodontic Benefits during the enrollee's lifetime is **$1,700.00.**

LIMITATIONS

1. Only the first two oral examinations, including office visits for observation and specialist consultations, or combination thereof, in a calendar year are Benefits while you and your Dependents are enrolled.

   Two additional examinations provided by a specialist are covered each calendar year while you and your Dependents are enrolled.

2. Full-mouth x-rays are Benefits once in a five-year period while enrolled in the Plan.

3. Bitewing x-rays are provided on request by your Dentist, but not more than twice in any calendar year while you and your Dependents are enrolled.

4. Diagnostic casts are a Benefit only when made in connection with subsequent orthodontic treatment covered under the Plan.

5. Only the first two cleanings, or Single Procedures which include cleaning, or combination thereof, in any calendar year are Benefits while you and your Dependents are enrolled.

   The Plan will pay for two additional cleanings each calendar year for periodontal maintenance.

6. Sealant Benefits include the application of sealants only to permanent first molars through age eight and second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.

7 Direct composite (resin) restorations are Benefits on anterior teeth and the facial surface of bicuspids. Any other posterior direct composite (resin) restorations are optional services and Delta Dental's payment is limited to the cost of the equivalent amalgam restorations.

8. Crowns, Jackets, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you or your Dependents are enrolled, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

9. Prosthodontic appliances are Benefits only once every five years, while you or your Dependents are enrolled, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if it is unsatisfactory and cannot be made satisfactory.

10. Delta Dental will pay the above percentage of the dentist's fee for a standard partial or complete denture. A standard partial or complete denture is one made from accepted materials and by conventional methods.

11. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your Plan. However, if implants are provided along with a covered prosthodontic appliance, Delta Dental will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If Delta Dental makes such an allowance, we will not pay for any replacement for five years following the completion of the service.

12. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee.

    For example: a crown where a silver filling would restore the tooth; or a precision denture where a standard denture would suffice.

13. If orthodontic treatment is begun before you become eligible for coverage, Delta Dental's payments will begin with the first payment due to the dentist following your eligibility date.

14. Delta Dental's orthodontics payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.

15. X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.

EXCLUSIONS/SERVICES WE DO NOT COVER

Delta Dental covers a wide variety of dental care expenses, but there are some services for which we do not provide Benefits. It is important for you to know what these services are before you visit your dentist.

Delta Dental does not provide benefits for:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws.

2. Services you or your Dependents receive from any Federal or State Governmental Agency or are provided without cost any municipality, county or other political subdivision, except Medi-Cal benefits.

3. Services for cosmetic purposes or for conditions that are a result of congenital (hereditary) or developmental (following birth) defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.

5. Any Single Procedure, bridge, denture or other prosthodontic service that started before the Enrollee was covered by this Plan.

6. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.

7. Experimental procedures.

8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

9. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.

10. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

11. Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants, except as provided under LIMITATIONS.

12. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.

13. Replacement of existing restoration for any purpose other than active tooth decay.

14. Intravenous sedation, occlusal guards and complete occlusal adjustment.

15. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this Plan.

COVERED FEES

It is to your advantage to select a dentist who is a Delta Dental PPO Dentist or a Delta Dental Dentist. A dentist who does not contract with Delta Dental may charge you any amount but the percentage Delta Dental will pay is limited to the Delta Dental PPO Dentists' fee.

Payment to a Delta Dental PPO Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged or a fee that the dentist has contractually agreed upon with Delta Dental to accept for treating enrollees.

Payment to a Delta Dental Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the Delta Dental PPO Dentist's Fee or the accepted fee the dentist files with Delta Dental.

Payment to a dentist, who is not a Delta Dental Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged or the Delta Dental PPO Dentist's Fee.

CHOICE OF DENTISTS AND PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

You are free to choose any dentist for treatment, but it is to your advantage to choose a Delta Dental PPO Dentist or other Delta Dental Dentist. This is because his or her fees are approved in advance by Delta Dental. And Delta Dental PPO and Delta Dental Dentists have treatment forms on hand and will complete and submit the forms to Delta Dental free of charge. You are responsible for filing the claims if the services were provided by a non-Delta Dental dentist.

If you choose a Delta Dental PPO Dentist, you receive the advantages of going to a Delta Dental Dentist and you may have a higher level of Benefits.

If you go to a non-Delta Dental Dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental Dentists may be submitted to Delta Dental at the address listed on page 1.

A list of Delta Dental PPO Dentists and Delta Dental Dentists can be obtained by calling 1-800-427-3237. This list will identify those dentists who can provide care for individuals who have mobility impairments or have special health care needs. You can obtain specific information about Delta Dental PPO Dentists and Delta Dental Dentists by using our web site – www.deltadentalins.com or calling the Delta Dental Customer Service Department at the number shown on page 1. A printed list of the Delta Dental PPO Dentists and Delta Dental Dentists in your area is also available by calling 1-800-427-3237.

Services may be obtained from any licensed dentist during normal office hours. Emergency services are available in most cases through an emergency telephone exchange maintained by the local dental society that is listed in the local telephone directory.

Services from dental school clinics may be provided by students of dentistry or instructors who are not licensed by the state of California.

Delta Dental shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta Dental cannot ensure your dentist's use of precautions against the spread of such diseases, or compel your dentist to be tested for HIV or to disclose test results to Delta, or to you. Delta Dental informs its panel dentists about the need for clinical precautions as recommended by recognized health authorities on this issue. If you should have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

CONTINUITY OF CARE

If you are undergoing a course of treatment and your dentist no longer is a Delta Dental PPO Dentist or a Delta Dental Dentist, you may continue to receive treatment from that dentist.

PUBLIC POLICY PARTICIPATION BY ENROLLEES

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communications from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to:

Delta Dental of California
Customer Service Department
P. O. Box 997330
Sacramento, CA 95899

SAVING MONEY ON YOUR DENTAL BILLS

You can keep your dental expenses down by practicing the following:

- ✓Comparing the fees of different dentists;
- ✓Using a Delta Dental Dentist;
- ✓Having your dentist obtain predetermination from Delta Dental for any treatment over $300;
- ✓Visiting your dentist regularly for checkups;
- ✓Following your dentist's advice about regular brushing and flossing;
- ✓Avoiding putting off treatment until you have a major problem; and

By learning the facts about overbilling. Under this Plan, you must pay the dentist your copayment share (see YOUR BENEFITS). You may hear of some dentists who offer to accept insurance payments as "full payment." You should know that these dentists may do so by overcharging your Plan and may do more work than you need, thereby increasing Plan costs. You can help keep your dental Benefits intact by avoiding such schemes.

YOUR FIRST APPOINTMENT

During your first appointment, be sure to give your dentist the following information:

- ✓Your Delta Dental group number (1988);
- ✓The employer's name (County of San Bernardino);
- ✓Your ID number (which must also be used by Dependents);
- ✓Your date of birth;
- ✓Any other dental coverage you may have.

PREDETERMINATIONS

After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are eligible and meet all the requirements of your Plan at the time the treatment you have planned is completed.

In order to receive a predetermination, your dentist must send an Attending Dentist's Statement to us listing the proposed treatment. Delta Dental will send your dentist a Notice of Predetermination estimating how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the statement to us for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the Enrollee is eligible. Payment will depend on the Enrollee's eligibility and the remaining annual Maximum when completed services are submitted to Delta Dental.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

REIMBURSEMENT PROVISIONS

Delta Dental will pay Delta Dental Dentists directly. Our agreement with our Delta Dental Dentists makes sure that you will not be responsible to the dentist for any money we owe. However, if for any reason we fail to pay a dentist who is not a Delta Dental Dentist, you may be liable for that portion of the cost. If you have selected a non-Delta Dental Dentist, Delta Dental will pay you. Payments made to you are not assignable (in other words, we will not grant requests to pay non-Delta Dental Dentists directly).

Delta Dental does not pay Delta Dental Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service. If you wish to know more about the method of reimbursement to Delta Dental Dentists, you may call Delta Dental's Customer Service department for more information.

Payment for any Single Procedure that is a covered service will only be made upon completion of that procedure. Delta Dental does not make or prorate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs when a charge is made against any Maximum under your Plan.

If there is a difference between what your dentist is charging you and what Delta Dental says your portion should be, or if you are not satisfied with the dental work you have received, contact Delta Dental's Customer Service department. Delta Dental may be able to help you resolve the situation.

Delta Dental may deny payment of any Attending Dentist's Statement for services submitted more than 12 months after the date the services were provided. If a claim is denied due to a Delta Dental Dentist's failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by Delta Dental (unless you failed to advise the dentist of your eligibility at the time of treatment).

The process Delta Dental uses to determine or deny payment for services are distributed to all Delta Dental Dentists. The process describes in detail the dental procedures covered as Benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the Plan. Claims are reviewed for eligibility and are paid according to these processing policies.

Claims requiring additional review are evaluated by Delta Dental's dentist consultants. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dental Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta Dental's Customer Service department for more information regarding Delta Dental's processing policies.

IF YOU HAVE QUESTIONS ABOUT SERVICES FROM A DELTA DENTAL DENTIST

If you have questions about the services you receive from a Delta Dental Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call our Quality Review department at 1-800-765-6003. If appropriate, Delta Dental can arrange for you to be examined by one of our consulting dentists in your area. If the consultant recommends the work be replaced or corrected, Delta Dental will intervene with the original dentist to either have the services replaced or corrected at no additional cost to you or obtain a refund. In the latter case, you are free to choose another dentist to receive your full Benefit.

SECOND OPINIONS

Delta Dental obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

Delta Dental will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Predetermination of treatment cost by a dentist. Delta Dental will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. Delta Dental will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta Dental to perform the clinical examination. When Delta Dental authorizes a second opinion through a Regional Consultant, the Plan will pay for all charges.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examination or consultant may be submitted to Delta Dental for payment. Delta Dental will pay such claims in accordance with the Benefits of the Plan.

This is only a summary of Delta Dental's policy on second opinions. A copy of Delta Dental's formal policy is available from Delta Dental's Customer Service department upon request.

GRIEVANCES

General Enrollees' Questions. You are encouraged to contact Delta Dental, the Third Party Administrator with questions regarding benefits, choice of Dentists, the status of a claim, or to report questions or concerns regarding the quality of care you or your Dependents received. Delta Dental can be reached by calling 1-800-765-6003 during normal business hours or by contacting them on the Internet at their web site: www.deltadentalins.com. You can also write Delta Dental at:

Delta Dental of California
PO Box 997330
Sacramento, CA 95899-7330

Claims Process. You or your Dentist may submit a claim to Delta Dental. Delta Dental processes claims within 30 days of receipt of the completed claim form. Documentation must include a completed and signed claim form, supporting radiographs and, when necessary, a narrative description and adjunctive documentation including periodontal charting, if applicable.

If the claim form is incomplete, Delta Dental will give you or your Dentist a description of any additional material or information necessary to evaluate the claim.

Within 30 days of receipt of a completed claim, Delta Dental will adjudicate the claim and give you a Notice of Payment (NOP) Statement. The NOP shall indicate:

a. The amount paid by the Plan,
b. The amount applicable for the annual plan maximum,
c. An explanation as to why a claim or a service was denied, and
d. Instruction on the claims grievances process and timeline.

All grievances must be received by Delta Dental within 180 days of the date of the Notice of Payment.

Grievances. Contact Delta Dental at 1-800-765-6003 for assistance or if you have any questions. The following process will apply:

Customer Service. Based on the initial telephonic contact, Delta Dental will respond to an inquiry or complaint telephonically through Delta Dental's Customer Service department. But, if you are dissatisfied with telephonic response, you can initiate a grievance by writing a response to the NOP statement or completing a Grievance/Claims Appeals Form. The letter and/or completed form should be returned to Delta Dental at:

Delta Dental of California
P. O. Box 997330
Sacramento, CA 95899-7330

Correspondence should include the group number (1988), your name and ID number, the inquirer's telephone number, a copy of the NOP and any other relevant information. If you ask and without charge, Delta Dental will give you copies of any pertinent document relevant to the claim, a copy of any internal rule, guideline, protocol and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying a claim.

Grievance Procedures. Delta Dental shall provide written acknowledgement within five calendar days of receipt of the grievance. If the appeal is deficient, Delta Dental will contact you within 30 calendar days to obtain the necessary information. On receipt of necessary information, Delta Dental will investigate the claim and the basis for the appeal. This may include direct contact with you or your Dentist. You will receive written notification of the disposition of the appeal within 30 days after receipt of the complaint.

Delta Dental takes into account all information, regardless of whether the information was submitted or considered initially. Certain cases may be referred to one of Delta Dental's regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Delta Dental's review is conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and Delta Dental will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Plan, Delta Dental shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

Emergency Grievances. If an appeal involves an imminent and serious threat to the Enrollee's health or if the Enrollee is experiencing serious pain or related symptoms, a response shall be provided to you within three calendar days of receipt of the complaint.

You can also file a complaint with the Department of Managed Health Care (DMHC) after you have completed the Delta Dental's grievance procedure or after you have been involved in the grievance procedure for 30 calendar days.

You can file a complaint with the DMHC immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's Health.

The California Department of Managed Health Care **(DMHC)** is responsible for regulating Delta Dental. If you have a grievance against Delta Dental or the Plan, you should first telephone Delta Dental at **1-800-765-6003** and use Delta Dental's grievance process before contacting the DMHC. Utilizing Delta Dental's grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If help is needed with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by this health plan, or a grievance that has remained unresolved for more than 30 calendar days, you can call the department for assistance. You may also be eligible for an Independent Medical Review (IMR).

If eligible for an IMR, the IMR process will provide an impartial review of medical decisions related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired.

The department's Internet Web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR application forms and instructions online.

An IMR has limited application to a dental program. Enrollees may request an IMR only if the dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an experimental procedure.

Second Opinion. As part of the appeal process, Delta Dental may require a second opinion from a Network Provider or Delta Dental Dentist. Delta Dental will arrange for the second opinion without any charge to you.

Final Appeal. If Delta Dental cannot resolve an appeal to your satisfaction, you may ask request that Delta Dental forward the appeal and all relevant documentation to the Plan Administrator (Employee Benefits and Service Division). The Plan Administrator shall review Delta Dental's records and findings to assure that proper consideration was given to all pertinent facts. The Plan Administrator may elect to utilize an independent Dental Consultant to review the claim and basis for the appeal.

The Plan Administrator shall have sole responsibility to make a final determination on the appeal, which shall be binding and conclusive on Third Party Administrator, the Enrollee or any other party. Such decision shall receive judicial deference.

Grievance Time Line. The following time frames apply to the grievance process:

You must initiate an appeal within one 180 of the date shown on the relevant Notice of Payment (NOP).

Delta Dental must acknowledge the grievance within five days of its receipt.

Delta Dental will notify you of the outcome of the appeal within 30 days of receipt of a complaint or grievance, unless unusual circumstances require an extension of time. In such case, you will be told of the special circumstances requiring the extension and the date by which a decision can be expected.

The Plan Administrator shall act on all final grievances within 60 days of notification.

RIGHT TO RECEIVE AND RELEASE INFORMATION

Upon enrollment in the Plan, participant agrees and authorizes Plan Administrator or Delta Dental without further consent of or notice to Enrollee to release or obtain from any dentist, other dental health care provider, insurance company, health maintenance organization or other health care provider, insurance company, health maintenance organization or other person or entity any information the Plan deems necessary to determine eligibility and to process benefit claims. By enrolling in the Plan, participant agrees to cooperate with the Plan and its Administrators in administering Plan Benefits. Whenever payments which should have been made by this Plan have been made by any other plan, participant agrees that this Plan shall have the right to reimburse the other plan the amount this Plan determines shall satisfy the coordination of benefits provision. Whenever this Plan pays out more than necessary, Enrollee agrees that the Plan shall have the right to recover the excess payment from any person to whom such payments were made, or any insurance company or other organization.

IF YOU HAVE ADDITIONAL COVERAGE

It is to your advantage to let your dentist and Delta Dental know if you have dental coverage in addition to this Plan. Most dental carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both dental plans - sometimes paying 100% of your dental bill. For example, you might have some fillings that cost $100. If the primary carrier usually pays 80% for these services, it would pay $80. The secondary carrier might usually pay 50% for this service. In this case, since payment is not to exceed the entire fee charged, the secondary carrier pays the remaining $20 only. Since this method pays 100% of the bill, you have no out-of-pocket expense.

Be sure to advise your dentist of all dental plans under which you have dental coverage and have him or her complete the dual coverage portion of the Attending Dentist's Statement, so that you will receive all benefits to which you are entitled. For further information, contact the Delta Dental Customer Service Department at the number in the USING THIS BOOKLET section.

OPTIONAL CONTINUATION OF COVERAGE (COBRA)

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You or your Dependents may be entitled to continue coverage under this Plan, at the Qualified Beneficiary's expense, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section are shown below.

Qualified Beneficiary means:

1. You and/or your Dependents who are enrolled in the Delta Dental plan on the day before the Qualifying Event, or

2. A child who is born to or placed for adoption with you during the period of continued coverage, provided such child is enrolled within 31 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1. The termination of employment (other than termination for gross misconduct), or the reduction in work hours, by your employer;

Event 2. Your death;

Event 3. Your divorce or legal separation from your Spouse; Domestic Partnership dissolution.

Event 4. Your Dependents' loss of dependent status under the plan, and

Event 5. As to your Dependents only, your entitlement to Medicare.

You means the Primary Enrollee.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the month in which Qualifying Event 1 occurs.

This 18 month period can be extended for a total of 29 months, provided:

1. A determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or becomes disabled at any time during the first 60 days of continued coverage; and

2. Notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. You must notify the employer within 30 days of any such determination.

If, during the 18 months continuation period resulting from Qualifying Event 1, your Dependents, who are Qualified Beneficiaries, experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

Your Dependents, who are Qualified Beneficiaries, may continue coverage for 36 months following the occurrence of Qualifying Events 2, 3, 4 or 5.

When an employer has filed for bankruptcy under Title II, United States Code, benefits may be substantially reduced or eliminated for retired employees and their Dependents, or the surviving Spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event. If you are the retiree, and you have lost coverage because of this Qualifying Event, you may choose to continue coverage until your death. Your Dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following your death.

ELECTION OF CONTINUED COVERAGE

Your employer will provide a Qualified Beneficiary with the necessary benefits information, monthly Dues charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give the employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial Dues to the employer, which includes the Dues for each month since the loss of coverage. Failure to pay the required Dues within the 45 days will result in the loss of the right to continue coverage, any Dues received after that will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their Dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Dues will be adjusted to reflect the changes made.

TERMINATION OF CONTINUED COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occurs:

1. The allowable number of consecutive months of continued coverage is reached;

2. Failure to pay the required Dues in a timely manner;

3. The employer ceases to provide any group dental plan to its employees;

4. The individual first obtains coverage for dental Benefits, after the date of the election of continued coverage, under another group health plan (as an employee or Dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this Plan; or

5. Entitlement to Medicare.

Once continued coverage ends, it cannot be reinstated.